

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2015
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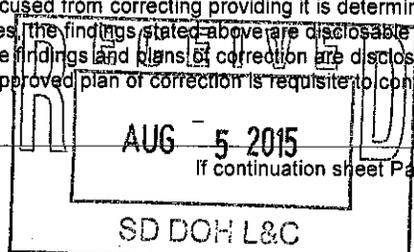
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/13/15 through 7/15/15. Highmore Health was found not in compliance with the following requirements: F252, F280, F281, F431, and F441.	F 000	<i>Addendum 5 noted with an asterisk per 8/24/15 telephone to facility administrator. DK(SOAH/JJ)</i>	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Surveyor: 16385 Based on observation, temperature testing, and interview, the provider failed to maintain a comfortable temperature in the main dining room. Findings include: Surveyor: 35237 1. Interview on 7/14/15 at 11:05 a.m. with a group of residents revealed the majority felt the dining room was too warm at times. Surveyor: 16385 2. Observation on 7/14/15 from 12:00 noon through 12:30 p.m. in the main dining room revealed several random residents fanning	F 252	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: F252 1.) The administrator, Maintenance Supervisor, and Interdisciplinary Team will review and revise as necessary the policy and procedure about monitoring and responding to elevated room temperatures. 2.) On unusually warmer than normal days, curtains in dining room will be closed, fans will be on, and A/C units will be turned on. 3.) Maintenance Supervisor or designee will audit dining room temperature weekly for 2 months and findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4.) Maintenance Supervisor or designee is responsible for this area of compliance.	9/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vick Bodur</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-3-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 252	Continued From page 1 themselves with their hands and napkins. Testing with a thermometer of the air temperatures during the meal service revealed: *Southwest corner by the wall heater the air temperature was 80.2 degrees Fahrenheit (F). *Northwest corner by the menu board the air temperature was 80.0 degrees F. *Northeast corner by the piano the air temperature was 79.7 degrees F. *Southeast corner by the entertainment center the air temperature was 79.5 degrees F. Testing with a thermometer of the air temperature during the evening meal service on 7/14/15 from 5:45 p.m. to 6:00 p.m. revealed: *Southwest corner by the wall heater the air temperature was 82.7 degrees F. *Northwest corner by the menu board the air temperature was 82.5 degrees F. *Northeast corner by the piano the air temperature was 83.6 degrees F. *Southeast corner by the entertainment center the air temperature was 82.5 degrees F. Interview on 7/15/15 at 2:30 p.m. with the administrator confirmed the dining room was warm. Testing at that time revealed the air temperature was 79.0 degrees F. He was not aware residents had been concerned about the temperature.	F 252	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: F280 1.) Care plans will be reviewed and revised as necessary for residents 6 and 9. 2.) Director of Nursing and Interdisciplinary Team will add signs and symptoms of depression to weekly meeting agenda. 3.) Director of Nursing or designee will audit all resident care plans for signs and symptoms of depression. Will audit 3 care plans a week until all care plans have been audited. DON or designee will update and revise care plans as necessary. Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4.) Director of Nursing or designee will be responsible for this area of compliance.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		9/3/15	

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F 280	<p>Continued From page 2 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans were revised and updated for two of two sampled residents (6 and 9) with depressive symptoms. Findings include:</p> <p>1. Observation and interview during initial tour on 7/13/15 of resident 6 revealed: *He shared a room with his wife. *The shades on the window were closed, and the room was dark. *He was sitting in his recliner, and his wife was laying in her bed. *He was alert but very hard of hearing. -His wife answered questions for him.</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>Random observations throughout the survey from 7/13/15 through 7/15/15 revealed:</p> <ul style="list-style-type: none"> *He spent a lot of time in his room in the recliner. *His room was usually dark with the shades on the window closed. *He used a wheelchair for mobility (getting around). *He came to the dining room for meals and sat at a table with his wife and two other residents. <p>Review of resident 6's medical record revealed:</p> <ul style="list-style-type: none"> *He was admitted on 8/29/14 from home at the same time as his wife. *His diagnoses included Parkinson's (progressive disease of the nervous system that affects movement), history of falls, diabetes (disease affecting the sugar levels in blood), and enlarged prostate with indwelling catheter (tube inserted into the bladder to drain urine) use. *On 7/2/15 the physician added a diagnosis of dementia (disease affecting memory). *He had been hospitalized for pneumonia (infection in the lungs) and urinary tract infection (infection in the bladder) in December 2014 and had returned to the facility on 12/16/14.. <p>Review of resident 6's Minimum Data Set (MDS) (document containing health information pertinent to the resident) assessments for 12/16/14, 3/10/15, and 6/9/15 revealed:</p> <ul style="list-style-type: none"> *His depression severity scores were: -Zero in December which indicated no depression. -Nine in March which indicated mild depression. -Fifteen in June which indicated moderate to severe depression. *The depression score was calculated from the mood and behaviors section of the MDS, and that section had been completed by: 	F 280			

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F 280	<p>Continued From page 4</p> <p>-Resident interview in December 2014. -Staff interview in March and June 2015.</p> <p>Review of the resident 6's current care plan revealed:</p> <p>*A focus area for behavior problem related to adjustment to nursing home and dementia that included interventions. -That focus area had not been revised since 3/17/15.</p> <p>*A focus area for "Mood problem r/t [related to] admission. Resident states he is sad because he and his wife are not able to agree on anything lately." -That focus area had not been revised since 12/2/14.</p> <p>*No new interventions had been added or revised related to his depression severity score worsening as indicated by the MDS in March and June 2015.</p> <p>Interview on 7/14/15 at 5:40 p.m. with the social services designee regarding resident 6 revealed she:</p> <p>*Completed the MDS sections related to mood and behaviors. *Agreed his depression score had worsened in March and again in June. *Was responsible for the mood and behavior areas on the care plan and revisions to those focus areas. -Agreed it had not been revised or updated since 12/2/14 and 3/17/15 for those areas. *Had not made any referrals related to his worsening depression score. *Had not updated his physician related to his worsening depression score. *Knew his family would have not wanted to add a medication for depression due to his sensitivity to</p>	F 280		

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F 280	<p>Continued From page 5 medications in the past. *Had not implemented any changes in his care related to those worsening depression scores. *Would look for more documentation related to his depression scores.</p> <p>Further interview on 7/15/15 at 8:55 a.m. with the social services designee regarding resident 6 revealed she was unable to find further documentation in his chart related to interventions for his depression score. She agreed his care plan had not changed related to his change in depression symptoms.</p> <p>Interview on 7/15/15 at 9:00 a.m. with the director of nursing (DON) regarding resident 6 revealed she: *Confirmed the social services designee would have completed the MDS and care plan areas for mood and behaviors. *Agreed his depression score had worsened as indicated by his MDS assessments in December 2014, March 2015, and June 2015. *She agreed the care plan did not appear to be revised related to depression score worsening. *She stated they were planning to start an interdisciplinary team meeting that would meet weekly. That team would review residents showing signs of depression, because they knew that was an area they could work on.</p> <p>Interview on 7/15/15 at 2:50 p.m. with the DON and MDS assessment nurse revealed: *All departments did their own areas of the long term care plans for each resident. *There were also short term care plans that the charge nurses could do. *All nursing staff had access to resident's care plans and should have referred to them for</p>	F 280		

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F 280	<p>Continued From page 6 instructions to care for each resident. *The DON agreed resident 6's short term care plan had no documentation that it had been revised related to his depression score worsening in March and again in June 2015.</p> <p>Surveyor: 32331 2. Review of resident 9's medical record revealed: *She was admitted on 7/1/10. *She had a diagnoses that had included Alzheimer's disease (memory loss) and dementia (a mental change in the thinking process) with depressive (sadness) features.</p> <p>Review of resident 9's 4/21/15 and the 1/27/15 quarterly Minimum Data Set (MDS) (document containing health information pertinent to the resident) assessment section D (mood information) revealed: *On the 4/21/15 assessment she had been feeling down, depressed, or hopeless nearly every day. *On both the 4/21/15 and the 1/27/15 assessments she had little interest or pleasure in doing things. *She had severity scores that could be interpreted as severe depression.</p> <p>Review of resident 9's revised 11/18/14 care plan revealed: *She had an inability to express emotion and to share information. *She had a decline in cognition (thinking). *She had difficulty in making her needs known. *That above care plan had not addressed depressive symptoms.</p> <p>Interview on 7/14/15 at 11:00 a.m. with the</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>director of nursing (DON) regarding resident 9 revealed she had reflected depressive type symptoms.</p> <p>Interview on 7/14/15 at 1:30 p.m. with the social services designee regarding resident 9 revealed:</p> <ul style="list-style-type: none"> *Depressive symptoms had not been addressed on her care plan. *She had her eyes closed most of the time. *She agreed the resident had severity scores on her MDS that could have been interpreted as severe depression. *Her physician had not been informed regarding the depressive-type symptoms. *There had not been interventions that addressed the depressive symptoms on her care plan. <p>Surveyor: 35237</p> <p>3. Review of the provider's undated Care Plan policy and procedure revealed:</p> <ul style="list-style-type: none"> *The purpose was "to include nursing diagnoses, goals and/or expected outcomes, and specific nursing interventions so that any nursing staff member is able to quickly identify a resident's individual needs and to decrease the risk of incomplete, incorrect or inaccurate care, and to enhance continuity of care." **4. Care Plans will be reviewed quarterly, annually and with any significant change in resident condition." <p>Review of the October 2013 Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, that the facility used as a reference revealed:</p> <ul style="list-style-type: none"> **The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity 	F 280		

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F 280	Continued From page 8 (disease). It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable." **Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan." **"Depression can be associated with: -psychological [emotional] and physical distress (e.g. [examples] poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain), -decreased participation in therapy and activities (e.g., caused by isolation), -decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and -poorer outcomes (e.g., decreased appetite, decreased cognitive status)."	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: F281 1.) Physician orders will be followed. Pharmacy labels will match physician orders. 2.) If there is a medication change desired, facility will fax physician and notify pharmacy once physician order is obtained. Nurses and Med Aides will review the facility policy and the 7 Rights of Medication Administration. Resident 11's oral medication will be given as ordered. Resident 12's pharmacy label will match physicians order. 3.) Director of Nursing or designee will audit Medication Administration Record (MAR), physician orders, and pharmacy labels weekly for 4 weeks and monthly for 2 more months. DON or designee will audit Medication Administration weekly for 4 weeks and monthly for 2 more months. Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4.) Director of Nursing or designee is responsible for this area of compliance.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Medication was given as ordered by the physician for one of one resident's (2) observed eye drop administration and one of one resident's (11) observed oral medication administration. *Medication labels matched the physician's order for one of one observed nebulizer (breathing medication) administration for one of one resident	F 281	<i>for resident 2 and all residents. OK (SAC) HJT</i>	9/3/15	

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F 281	<p>Continued From page 9</p> <p>(12) and one of one resident's (11) observed oral medication administration. Findings include:</p> <p>1. Observation on 7/14/15 at 10:02 a.m. of resident 2's eye drop administration by medication aide A revealed she had given one drop of Refresh tears into each eye.</p> <p>Review of resident 2's physician's order revealed Refresh tears two drops into each eye should have been given.</p> <p>Interview with medication aide A after the above observation confirmed she had only given one drop into each eye, and the order was to give two drops. She agreed she had not followed the physician's order.</p> <p>Interview at 7/15/15 at 9:00 a.m. with the director of nursing (DON) confirmed resident 2's eye drop had not been administered as ordered by the physician.</p> <p>2. Observation and interview on 7/14/15 at 4:55 p.m. of resident 11's oral medication administration with registered nurse (RN) B revealed:</p> <p>*She had given the resident's omeprazole (stomach medication) 40 milligrams (mg). *The label for the omeprazole stated it was to be given twice a day, in the morning and at bedtime. -She agreed the label did not match the time it was listed to be given on the resident's medication administration record (MAR). *She would have to check the physician's order.</p> <p>Review of resident 11's physician's orders revealed the omeprazole was ordered to be given</p>	F 281			

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F 281	<p>Continued From page 10 in the morning and at bedtime.</p> <p>Interview on 7/14/15 after the above observation with RN B and the DON regarding the above observation revealed: *The omeprazole had not been given as ordered by the physician. *They agreed the medication label was the same as the physician order, but those labels had not matched the MAR. -The MAR was what the nurse or medication aide would have used to know when to administer medications. *The DON stated the resident had probably requested those times for the medication to be given. If so the physician's order should have been clarified, and the pharmacy should have been notified.</p> <p>3. Observation on 7/14/15 at 10:25 a.m. of resident 12's nebulizer administration with medication aide A revealed: *She had given a Duoneb (brand name type of breathing medication) as indicated on the MAR. -The medication label stated to give it every six hours.</p> <p>Review of resident 12's physician's orders revealed: *The Duoneb was ordered four times a day. -It did not match the pharmacy label that stated every six hours.</p> <p>Interview on 7/15/15 at 9:00 a.m. with the director of nursing regarding resident 12's nebulizer revealed: *She agreed the label did not match the physician's order. *They had probably clarified or changed the</p>	F 281			

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F 281	<p>Continued From page 11</p> <p>order, so the resident would not have to be woken up at night for the nebulizer since it was originally every six hours.</p> <p>*They should have notified pharmacy of the order change</p> <p>*The label should have matched the physician's order.</p> <p>Review of the provider's January 2005 Individual Medication Orders policy revealed:</p> <p>***1. Dosages of drugs shall be given to residents only upon prescriber's written order or verbal order..."</p> <p>***b. Any dose or order that appears inappropriate, considering the resident's age, condition, or diagnosis, is verified with the attending physician."</p> <p>Review of the provider's June 2005 Labeling of Medication policy revealed:</p> <p>***A. All medications, prescription and over-the-counter, dispensed by the Pharmacy for individual resident use will be labeled with the following:"</p> <p>- "5. Directions for use."</p> <p>***C. Nurses may not label medications nor may they alter or modify a label. Nurses may apply "direction change" labels or "date opened" labels."</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed:</p> <p>***"Medications are administered as prescribed in accordance with good nursing principles and practices..."</p> <p>***2. Medications are administered in accordance with written orders of the attending prescriber...</p> <p>***5. All current medications and dosage</p>	F 281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2015
NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH STREET SE HIGHMORE, SD 57345		
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F 281	Continued From page 12 schedules, except topicals used for treatments, are listed on the resident's medical administration record (MAR)." **18. Seven Rights of Medication Administration: -Right Resident. -Right Medication. -Right Dose. -Right Route. -Right Time. -Right to know about their medication. -Right to Refuse their medication."	F 281			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: F431 1.) Director of Nursing will review and revise as necessary policy and procedure about destruction of fentanyl patches. 2.) Fentanyl patches will be destroyed and flushed down toilet by two nurses. 3.) Director of Nursing or designee will audit fentanyl patch destruction weekly for 4 weeks and monthly for 2 more months. Findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4.) Director of Nursing of designee will be responsible for this area of compliance.	9/3/15	
			*Destruction of fentanyl patches in-service was held on August 11, 2015 and included licensed nursing staff. DK/soam/JJ		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 13</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to have a system in place to secure Fentanyl (government-controlled narcotic pain medication) awaiting destruction. Findings include:</p> <p>1. Interview on 7/14/15 at 2:15 p.m. with the director of nursing (DON) revealed: *When Fentanyl patches were removed from a resident's skin: -The day nurse kept the patch locked in the medication cart until the night nurse arrived. -They would have cut the patch in half and put it into the sharps container (a box that contained sharp objects such as used needles) on the medication cart. *After the sharps container was full it was given to the maintenance supervisor. *She had been unsure what the maintenance supervisor did with the full sharps containers after that. *She agreed narcotics should have been accounted for from the time they arrived in the facility until the time of destruction or when they left the facility.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 431	<p>Continued From page 14</p> <p>Interview on 7/15/15 at 9:00 a.m. with the DON regarding the Fentanyl patches going into the sharps containers to be destroyed revealed she agreed they:</p> <ul style="list-style-type: none"> *Should have been accounted for from the time they arrived until they were destroyed. *Should have only been accessible to authorized staff. <p>Interview on 7/15/15 at 9:50 a.m. with the maintenance supervisor regarding the sharps biohazard (substances that pose a threat to humans, such as medical waste) containers revealed:</p> <ul style="list-style-type: none"> *The nurses gave him the full containers. *He took them and put them into large red biohazard barrels. -Those barrels were stored in an outside shed that was not attached to the building. *A biohazard waste company came periodically to pick up the barrels. *The shed stored many other items including a facility vehicle and extra furniture and parts. -It was unlocked during the day. -He locked it when he left for the day around 3:00 p.m. -The keys were hanging in the maintenance storage area. -All staff had access to the keys and the shed. -He agreed anyone could have accessed the shed when it was unlocked. <p>Observation of the shed revealed:</p> <ul style="list-style-type: none"> *It was across the parking lot from the side of the building. *It had a walk-in and a roll-up garage door. <p>Review of the provider's undated Sharp policy revealed "After bio-hazardous containers are full,</p>	F 431			

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F 431	Continued From page 15 they are placed in a special box for disposal. When a box is full the waste disposal company picks up the box for destruction." Review of the provider's undated Destruction of Fentanyl Patches After Removal from a Resident policy revealed: *"Destruction of used Fentanyl patches will be completed in accordance with all applicable rules and regulations in adherence to this policy and procedure. *2. Gently remove the patch from the resident. Fold the patch in half and dispose of by placing both halves in the sharps container." Review of provider's undated Drug Destruction Guidelines policy revealed: *"Destroy per Consulting Pharmacist protocol/recommendation. *Controlled medications are to be destroyed by the Consulting Pharmacist and a Registered Nurse on a monthly basis."	F 431	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: F441		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	1.) Director of Nursing will review and revise as necessary policy and procedure about appropriate hand washing, hand hygiene, and gloving. 2.) Appropriate hand washing, hand hygiene, and gloving in-service will be held August 11 th 2015 and include medication aide A, (RN) B, and (CNA) C and other staff involved in hand washing, hand hygiene, and gloving. 3.) Director of Nursing or designee will audit hand washing, hand hygiene, and gloving weekly for 4 weeks and monthly for 2 more months and findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by committee. 4.) Director of Nursing or designee is responsible for this area of compliance.	9/3/15	

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F 441	<p>Continued From page 16</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to ensure proper handwashing or hand hygiene had been completed during: *One of one observed resident's (2) eye drop administration by medication aide A. *One of one observed resident's (13) nasal spray administration by medication aide A. *One of one observed resident's (12) nebulizer administration by medication aide A. *One of one observed resident's (11) dressing changed by registered nurse (RN) B.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 17</p> <p>*One of one observed resident's (3) urinary catheter (a tube inserted into the bladder to drain urine) care by certified nursing assistant (CNA) C. Findings include:</p> <p>1. Observation on 7/14/15 at 10:02 a.m. of resident 2's eye drop given by medication aide A revealed she:</p> <ul style="list-style-type: none"> *Entered the resident's room. *Applied gloves. *Administered the eye drop. *Removed her gloves. *Did not perform hand hygiene prior to or after removing the gloves. *She left the room and returned to the medication cart by the nursing station. <p>2. Observation on 7/14/15 at 10:05 a.m. of resident 13's nasal (nose) spray administration by medication aide A revealed:</p> <ul style="list-style-type: none"> *She entered the resident's room with the nasal spray bottle. *She handed the bottle to the resident. *The resident administered the nasal spray to herself with the medication aide's assistance. *She left the room and returned the nasal spray bottle to the medication cart by the nursing station. *She did not perform hand hygiene during the observation. <p>3. Observation on 7/14/15 at 10:25 a.m. of resident 12's nebulizer (breathing medication) administration by medication aide A revealed:</p> <ul style="list-style-type: none"> *She entered the resident's room with the nebulizer medication. *She added the medication to the nebulizer unit. *She applied the nebulizer mask to the resident's face. 	F 441			

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F 441	<p>Continued From page 18</p> <p>*While waiting for the nebulizer to be completed she assisted the resident's roommate to remove her shoes.</p> <p>*After the nebulizer was finished she:</p> <ul style="list-style-type: none"> -Removed the mask from the resident's face. -Carried it to the resident's bathroom. -Rinsed it under the running water. -Wrapped it with a paper towel. -Placed it back with the nebulizer machine. -Then left the room. <p>*She had not performed hand hygiene during the above observation.</p> <p>4. Interview of medication aide A following the above three observations revealed:</p> <ul style="list-style-type: none"> *Hand hygiene was important to decrease the potential of spreading germs. *She had not performed hand hygiene appropriately during the administration of the eye drop, nasal spray, or nebulizer. <p>Interview on 7/15/15 at 9:00 a.m. with the director of nursing (DON) regarding the above observations revealed she would have expected infection control to be maintained. She would have expected hand hygiene to have been completed per the facility policy.</p> <p>Review of the provider's January 2005 Medication Administration General Guidelines policy revealed "Medications are administered as prescribed in accordance with good nursing principles and practices..."</p> <p>5. Observation and interview on 7/14/15 at 10:37 a.m. of RN B during resident 11's dressing change revealed she:</p> <ul style="list-style-type: none"> *Entered the room with the dressing change supplies in a plastic container with a handle. 	F 441			

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F 441	<p>Continued From page 19</p> <ul style="list-style-type: none"> *Set that plastic container on the floor. *Washed her hands. *Knelt on the floor. *Applied gloves. *Removed the dressing from the resident's lower leg wound and disposed of it in the trash can. *Removed the gloves. *Applied new gloves. *Sprayed wound cleanser onto gauze pads and cleaned the wound. *Removed those gloves. *Applied new gloves. *Used a cotton-tipped applicator and applied the ointment to the wound. *Applied the dressing to the area. *Removed the gloves. *Picked up the plastic container of dressing change supplies and left the room. *Returned to the medication room. *Unlocked the medication room door *Set the plastic container on the treatment cart. *Then washed her hands in the sink in the medication room. *Agreed she had not done hand hygiene between removing gloves and applying new gloves or prior to leaving the resident's room. -Confirmed she should have done hand hygiene at those times. <p>Interview on 7/15/15 at 9:00 a.m. with the DON regarding resident 11's dressing change observation revealed she would have expected hand hygiene to be completed between glove changes. She would have expected hand hygiene to be completed according to the facility policy.</p> <p>Review of the provider's 2006 Clean Dressing Change policy revealed the purpose was to protect the wound, prevent irritation, prevent</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2015
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F 441	<p>Continued From page 20</p> <p>infection and spread of infection, and to promote healing.</p> <p>6. Observation and interview on 7/15/15 at 10:35 a.m. of CNA C during resident 3's catheter care revealed she:</p> <ul style="list-style-type: none"> *Entered the room. *Washed her hands. *Applied gloves. *Emptied the resident's catheter bag into a plastic container. *Dumped the plastic container into the toilet in the resident's bathroom. *Wrapped a paper towel around the plastic container. *Left the resident's room. *Went across the hall. *Entered the code to unlock the soiled utility room door. *Rinsed the plastic container in the hopper (type of utility sink that has a sprayer and flushing capability). *Disinfected the plastic container. *Used the handle of the hopper and flushed it. *Set the container in the soiled utility room sink. *Removed the gloves. *Went back to the resident's room. *Washed her hands in the resident's bathroom. *Agreed her gloves were contaminated after she emptied the resident's catheter. *Agreed touching the door and other surfaces with contaminated gloves had not been appropriate. *Agreed hand hygiene had not been completed appropriately. <p>Interview on 7/15/15 at 10:50 a.m. with the DON regarding the above observation confirmed there would have been multiple surfaces contaminated</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2015
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F 441	<p>Continued From page 21 during the process. She agreed handwashing had not been done appropriately.</p> <p>Review of the provider's revised November 2002 Catheter Care Emptying a Urine Collection Bag policy revealed "Hands are washed before and after every procedure with the catheter and drainage system. To prevent cross-contamination."</p> <p>Review of the provider's updated August 2011 Non-Sterile Glove policy revealed: *The purpose was "to prevent the transmission of pathogens by direct and indirect contact." *The procedure included: -1. Wash hands. -2. Apply clean non-sterile gloves whenever there is potential for: -a. Contact with blood. -b. Contact with any body fluid, secretions, or excretions. -c. Contact with moist mucus membranes. -d. Contact with non-intact skin. -e. Contaminated items or surfaces. -3. Change gloves between each tasks and procedure. -4. Remove gloves promptly after use. -5. Perform hand washing immediately."</p> <p>Review of the provider's updated August 2011 Hand Washing Policy and Procedure revealed: *The purpose was to control infection and reduce the spread of infection from resident-to-resident, nursing staff-to-resident, and resident-to-nursing staff. *General instructions included: -"Wash hands before and after any resident care/contact. -Wash hands after any personal hygiene cares.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 441	Continued From page 22 -Wash hands with soap and water whenever visibly soiled." *For Alcohol Based Hand gels/sanitizers: -"1. May be used whenever hands are not visibly soiled, before and after any resident contact, before and after eating or assisting resident with food, after any personal hygiene needs."	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/21/15. Highmore Health was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nite Bedu

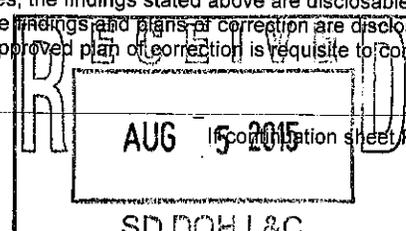
TITLE

Administrator

(X6) DATE

8-3-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10628	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/21/2015
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NAME OF PROVIDER OR SUPPLIER HIGHMORE HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 410 8TH ST SE HIGHMORE, SD 57345
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/13/15 through 7/15/15 and on 7/21/15. Highmore Health was found not in compliance with the following requirement: S130.	S 000		
S 130	44:04:02:06 FOOD SERVICE Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions in the kitchen were maintained for five of six shelving units with uncleanable surfaces in the dry food storage area. Findings include: 1. Observation on 7/13/15 in the kitchen from 4:10 p.m. through 4:35 p.m. revealed:	S 130	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: S130 1.) Dietary Manager will review and revise as necessary Dry Storage Policy. Shelving units in the dry food storage room will be replaced. 2.) Shelving and storage units in dietary kitchen will be inspected for chipping and unfinished wood surfaces. 3.) Dietary Manager or designee will audit dietary kitchen weekly for 4 weeks and then monthly for 2 more months and findings will be reported to monthly QAPI committee meetings with further follow-up as recommended by the committee. 4.) Dietary Manager or designee will be responsible for this area of compliance.	9/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

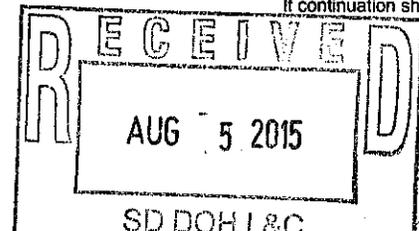
Mike Bodur

TITLE

Administrator

(X6) DATE

8-3-15



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10628	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2015
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S 130	<p>Continued From page 1</p> <p>*Shelving units in the dry food storeroom had a moderate amount of chipped and unfinished wood on them.</p> <p>*Those shelves contained residents' food and supplies on them.</p> <p>*Those above shelving units were no longer cleanable surfaces.</p> <p>Interview on 7/14/15 at 9:15 a.m. with the dietary manager regarding the above dry food storeroom in the kitchen revealed she agreed:</p> <p>*The shelving units in the dry food storeroom had a moderate amount of chipped and unfinished wood and needed to have been refinished or replaced.</p> <p>*Those above shelving units were no longer cleanable surfaces.</p> <p>Review of the provider's September 2014 Dry Storage Area policy revealed the dry storage areas would have had shelves kept clean.</p> <p>Review of the provider's undated Food Storage policy revealed food was to have been stored by methods to prevent contamination.</p>	S 130		